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Homelessness: Causes, Culture and
Community Development as a Solution
By Kaitlin Philipps

A Thesis Submitted to
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Abstract

This thesis seeks to explain the reasons that homelessness occurs, and how it is currently being dealt with in public policy. Triggers and predictors of homelessness are explored and it is shown that triggers are almost always compounded, indicating a multitude of factors that lead to homelessness. The culture and community surrounding the homeless lifestyle is seen as playing a significant role in how the individual copes with their homelessness. The norms and values of their culture are investigated and its role in rehabilitation is explored. Current institutions for helping the homeless are analyzed for different success rates. Additionally, initiatives and solutions to homelessness from two Western countries, The United States and Denmark are compared for varying successes and failures. Based on the analyzed factors this thesis proposes what could be done to improve the situation of homeless individuals by shaping public policy. Specifically the benefits that community building programs of rehabilitation such as Assertive Community Treatment and Critical Time Intervention could offer if public policy was changed to increase their use are discussed. Specifically, Assertive Community Treatment and Critical Time Intervention are advocated for due to their ability to encourage community development in conjunction with its use of community creation as a tool in decreasing recidivism rates and creating long term solutions for homeless individuals and their reintegration into society.

Keywords: Assertive Community Treatment, Critical Time Intervention, Community, Culture, Homelessness, Predictors, Solutions

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Homelessness: Causes, Culture and Community Development as a Solution

Introduction

Throughout history there has always been a substantial segment of the population that is living in less than ideal conditions. Some of the first written accounts of homelessness are seen from as far back as the middle ages (Cope, 1990). It would seem that during this century of abundance, there should not be individuals without food or shelter. Unfortunately, there are millions who go without a proper place to sleep every night. Homelessness is so contrary to the condition that most of us find ourselves in, we are repulsed by the idea. By extension, we are often repulsed by those individuals in this unfortunate status. Shelter, after food, is considered the most essential ingredient for survival and success. There are a myriad of contributing factors that lead to homelessness. The strongest predictor is a tumultuous upbringing. Instability within the home is the greatest catalyst of most mental health problems and by extension substance abuse and other psychological unsteadiness. First definitions of the major terms used are examined.

Homelessness, rooflessness and rough sleepers

Definitions have the ability to contour the discourse and give power to those who create the terms. Words have the ability to illicit images and emotions which have the potential to be transformed into action. Different countries and organizations define homelessness differently and it directly affects the sort of goals they want to accomplish in relation to homelessness. Though individuals who are homeless are often roofless it is important to make a distinction between the terms rooflessness and homelessness. It is also important to define precisely what it means to have a home.

As common wisdom would indicate, a house is not necessarily a home and there are additional components that must be incorporated. Home is more than just a physical place. It is associated with a sense of safety, a feeling of freedom and the ability to be oneself. It is also most associated with a set of social connections that can be considered family, regardless of blood relation. It is the base which work, friendship and all other activities can be developed (Wilkinson, 1995). Conversely, a physical place where a person can stay, but feels no social or meaningful connection to the environment is considered a shelter (Smith and Ravenhill, 2007). This becomes important to incorporate because an individual may feel at home on the streets because of their social situation and connection to their environment, regardless of how unconventional it may be. This can have an effect on resettlement and circumstances regarding rehabilitation.

Additionally, there needs to be a distinction between different categories of homelessness. First there is rooflessness, which encompasses those individuals who have no roof over their heads. These people sleep on the streets, park benches and under trees. Rough sleeping is an instance of sleeping on the street (Smith and Ravenhill, 2007). Next there is houselessness. This includes those who are living in cars, tents, sheds or other places which make them technically not roofless. Next there is precariously housed which includes those individuals who squat, stay in hostels, hotels, friends floors or those who are about to be evicted (Ravenhill, 2008).

Triggers and Predictors of Homelessness

The path to homelessness is not a single event that occurs right before the emergence into homelessness. Much of the literature on the subject focuses on the experience faced immediately before their entry into homelessness, but this has done an insufficient job at explaining the

entirety of the situation. More recent studies on the subject have done much to change our understanding (Ravenhill, 2008). Instead, it is a complex series of events over a lifetime that leads to this precarious situation. It is not just the predictors of homelessness, but the accumulation of these triggers over time. Another major factor is not just the events, but the affect the events have on the individual. Some triggers can occur to one individual who may never become homeless, while another can be seriously affected. Triggers most often start in childhood. It is the combination of problems that compound the situation where homelessness can occur. In a study conducted by Paul Koegal (1995) it was found that two or more predictors were identified in 62% of those homeless interviewed. This demonstrates the highly comorbid nature of experiences that lead to homelessness.

One major predictor is frequent or disruptive childhood moves. Many homeless individuals have a history of constantly moving during their childhood. Moving is a major stressor for anyone. The movement from one place to another often involves separation from the people and places one knows. With each new move entirely new relationships must be formed. This can be done, but when the process of moving is repeated frequently it can become increasingly stressful. This process is difficult for children, especially if changing schools is necessary for the move. The lack of reliable relationships creates isolation and insecurity. Constantly moving does not necessarily indicate that a child will be at risk for homelessness in the future. Nevertheless, it is cited because it is often associated with instability on the part of the parents. Even in those individuals who never became homeless but frequently moved, it was seen that they had difficulty forming strong bonds, preferring superficial relationships which were easier to end. They were also seen to continue with their transient lifestyle (Ravenhill, 2008).

When combined with alcoholism or violence within the home the damaging effects of this insecurity can be overwhelming.

Physical and sexual abuse in childhood are reliably seen as leading to a host of major problems associated with a lack of wellbeing and proper adjustment in all stages of life. Abuse has a highly negative effect on an individual's ability to properly cope with stress, form stable relationships, make good decisions or have a healthy self-esteem which in turn makes them far more vulnerable to mental health and substance abuse issues (McIntee & Crompton, 1997; Richardson and Bacon, 2003). Violence against the child or violence witnessed by the child are both included in having these negative effects. This atmosphere becomes the norm and some of these individuals are able to acclimate to the circumstances. This in turn reduces the amount of fear they contend with in dangerous experiences. This ability can help make the transition to the streets, and the violence that occurs there, easier to tolerate. Depending on how severe the abuse occurring at home is, homelessness can be seen as a solution to their problems. This is especially seen in youth due to their mental immaturity and their inadequate exposure to role models who have properly coped with unfortunate life experiences from whom they can learn (Ravenhill, 2008).

The age of first entry into rooflessness and homelessness appears to be one of the greatest indicating factors of long term homelessness. Those who become homeless during their teenage years have an increased likelihood to remain homeless. Such instability at such a young age has the enormous impact to escalate their situations. It often leaves the individual with a lack of skills to return to settled life. Often education is terminated and employment is difficult to secure. Proper social skills are also not established, which is especially detrimental for the developing child or adolescent mind. Additionally, in order to survive as a homeless person,

behavior and cultural habits unique to the homeless community are acquired, making it increasingly difficult to reestablish themselves into mainstream society where the norms and values are different (Social Exclusion Unit, 2001).

Koegel's study did much to illuminate the conditions where individuals would be more likely to end up homeless. Most notably, 25% of the individuals indicated living separately from their parents at some point in their childhood and 60% reported receiving welfare during childhood and/or living in impoverished conditions with inadequate food or water. It was also found that 32% reported that there was a substance abuser within their household (Koegal, 1995). Substance abuse, much like mental illness is a problem which is often propagated (Meller, 1988; Miles, 1998).

Substance Abuse

There is a misconception that all homeless people are in their situation because they were drunks and therefore brought their situation upon themselves. Inevitably this perception creates a tension among authorities and the society at large and negatively affects their desire to help assist these vulnerable people. However exaggerated this stereotype may be there does remain a strong link between substance abuse and homelessness. Substance abuse is both a cause and consequence of homelessness. There is a much higher rate of alcohol and drug abuse in the homeless community than the community at large. It has been estimated that 38% of the homeless population suffers from alcoholism and 26% abuse drugs (National Coalition for the Homeless, 2009). This compares to 15% and 8% in the general population (Substance Abuse and Mental Health Services Administration, 2006). In a 2008 American study done by the United States Conference of Mayors, 35 cities were asked what the three largest contributors of homelessness were. For single adults substance abuse was cited as the single largest factor with

68% reporting. For homeless families this percent was 12%, still making it a major contributing factor (The United States Conference of Mayors, 2008). When substance abuse is not a trigger for homelessness, it often appears later as a result of the homelessness. This can be for a variety of overlapping reasons. Most obviously is the desire to numb emotion and physical pain. Since homeless individuals have such traumatic pasts, many suffer from flashbacks and anxiety they cannot control and alcohol and drugs are used to cope. Drugs and alcohol are utilized in order to sleep, especially when the weather is cold. Additionally it is entrenched in the culture of the homeless and is used as a bonding tool and social activity. The priorities of these individuals are on survival, finding adequate food or shelter for the night. These reasons mean that the motivation to quit drugs or alcohol is low, even though its absence from their life would be highly advantageous. Compounded by a lack of adequate social structure for support, sobriety can be short lived and exceptionally hard to maintain. Interestingly there seems to be evidence to suggest that those who abuse drugs and those who abuse alcohol do not often interact within the homeless community (Danczuk, 2000). This perhaps can be explained by the generational difference seen between the populations with older homeless individuals most commonly abusing alcohol while homeless adolescents and young adults are more likely to abuse drugs (Didenko and Pankratz, 2007).

The resources available for the homeless to get sober are often inadequate or simply “quick fixes”, and almost always result in relapse. Additionally, due to the shortage of space at detox facilities or similar accommodations, individuals often wait up to 12 months before admittance (Fountain and Howes, 2002). Short term detoxification programs are used by the individual to curb their addiction or take a break, especially if they feel their health is deteriorating. It offers the opportunity to clean up for the short term and allow the body to

recover. Unfortunately this strategy is often not used with the intention of staying sober. Additionally entering into a detoxification center jeopardizes the individual's shelter opportunities. If they forfeit their spot at a hostel or shelter upon release from detox they will have no choice but to return to the streets. Through case studies it appears that there is little evidence that detox centers work to help secure shelter for the individual upon their release (Ravenhill, 2008).

Substance abuse seriously impedes upon a homeless individual's ability to make positive changes in their life. Firstly, in American and many other cultures, substance abuse is demonized and seen as a personal issue, and therefore the individual is seen as solely responsible for their circumstance. They are seen as undeserving of help and this makes it difficult to receive an advantageous placing on authority housing waiting lists. Addiction can cause individuals to prioritize satisfying their craving above all else. When the individual is housed, often they are unable to budget properly or even maintain personal hygiene. If they are not adequately supported for their substance abuse upon their housing placement, they often return to the streets. Additionally their desire for their substance can result in drastic measures such as crime, once again making authorities reluctant to help.

Mental Illness

Due to the often traumatic circumstances that homeless individuals cope with throughout life, it is unsurprising that high rates of mental illness are observed in this population. In the 2008 survey by the U.S Conferences of Mayors, mental illness was cited as the third largest cause of homelessness with 48% of cities reporting this fact (The United States Conference of Mayors, 2008). Mental illness is not uncommon within the general population, and is seen at a rate of 6%.

However, in the homeless population this number dramatically increases, with nearly 25% of the population suffering from a mental illness (National Institute of Mental Health, 2009).

Mental illnesses are medical conditions that primarily affect the functioning of the mind. It can affect an individual's mood, emotions and their thought processes. Their ability to function in daily living is often diminished, reducing their ability to take care of themselves or their living environment. Mental illness also has a serious affect on an individual's ability to form and maintain relationships. Issues revolving around the illness can push those closest to the individual away and often these are the people who would be keeping the mentally ill individual off the streets (National Coalition for the Homeless, 2009).

Depression

The most common form of mental illness within the homeless community is depressive disorders, constituting nearly 25% of the mentally ill population within the homeless population. Depression is a disease that controls an individual's outlook on life and their ability to deal with circumstances. Depression is characterized by an all encompassing low mood. It causes low self-esteem, a loss of interest in activities once found enjoyable and has an incapacitating affect on the individual's ability to relate to others (National Institute of Health, 2011). Often depression can be a trigger for homelessness or can be created by being homeless (Marcuse, 1988). One of the strongest sources of depression among the homeless community was their feelings of isolation and loneliness. Feelings of isolation and separation from others have a reciprocal relationship with triggers for rooflessness, such as parental neglect. Depression and resulting suicide constitute nearly a quarter of the deaths among the homeless compared to only 1% in the general population (Votta, 2003).

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder, also known as PTSD is a severe anxiety disorder that can develop after a serious psychological trauma. The trauma may be threat of one's life or the life of someone near to them or a threat to their psychological integrity. Such events can include war, rape, or abuse. Symptoms include the individual reliving the traumatic event, emotional numbing and detachment and heightened arousal for danger. Nearly a quarter of homeless individuals are thought to have Post-Traumatic Stress Disorder (Cockersell, 2006). PTSD is highly comorbid with depression and many of the symptoms are related. Additionally, PTSD like depression can be both a cause and consequence of homelessness. If the homeless individual does not suffer from PTSD upon their emergence into homelessness, the circumstances they face on the streets can be traumatic enough to trigger the disorder. PTSD has been shown to be successfully treated with therapy, but due to the homeless individual's circumstance this is often not possible. Consequently they will self-medicate in order to cope with the severe distress they endure. This is most often done by abusing drugs and alcohol, once again illustrating the interrelated nature of these issues (National Institute of Health, 2012).

Schizophrenia

Schizophrenia is somewhat unique among the mental illnesses discussed due to the nature of the illness and how it develops. Unlike depression and PTSD, Schizophrenia is not an illness that will develop in otherwise healthy individuals based on their harmful environment alone. This is not to say that depression and PTSD do not also have a genetic component that predisposes individuals to developing these disorders. However, developing schizophrenia has an almost exclusive biological and genetic component. Therefore, Schizophrenia is a cause of homelessness rather than a consequence of it. Schizophrenia is one of the most debilitating and

difficult mental illnesses to suffer from. It affects the very foundation of reality and can make the tasks of everyday life exceptionally difficult. The symptoms of schizophrenia can be separated into two categories. The first category is known as positive symptoms. They are called positive because they are additional sensory experiences not seen in healthy people. These primarily include hallucinations and delusions. Hallucinations are sensory perceptions such as sounds, smell and sights that no one else can see. Delusions are false beliefs which remain consistent for the individual regardless of whether or not they have been proven wrong. There are also negative symptoms, so called because they are behaviors seen in a healthy individual but not seen in the schizophrenic. These include a lack of ability to find pleasure in life or sustain activities, and a lack of desire to speak or interact with others. Additionally there are cognitive symptoms which include an inability to focus or remember information just learned, and a decreased ability to make decisions or apply skills to problem solving (National Institute of Mental Health, 2011).

These symptoms cause great distress to the individual and make even the most basic aspects of life difficult to handle. Individuals with schizophrenia have difficulty maintaining relationships and holding down jobs. When schizophrenia is not properly treated, as is the case with a majority of the homeless with the disorder; there are many risks and dangers that can arise for the individual and the people around them.

Gender Differences and Issues among the Homeless

Just as men and women in mainstream society face different issues, and have different expectations imposed on them by society; homeless men and women also have different issues related to their circumstances. As a result it is important to understand these differences in rehabilitation services so they can best meet the needs of this population.

Homeless Women

Of the estimated 3.5 million homeless in America, 17% were single women and 30% were families with children (National Coalition for the Homeless, 2008). In a meta-analysis conducted by Finfgel-Connet, black women made up 46% of the female homeless population. A majority of these women have suffered from neglect, poverty, and parental mental health issues from a young age. As a result of these poor conditions, maladaptive behaviors often arise, which helps to perpetuate their circumstances. Some of the behaviors that these women exhibit include: sub-clinical anxiety, substance abuse, low self-esteem, mood disorders and psychosis. Homeless women are more likely to suffer from depression than their male counterparts, but this is also true in the general population (Finfgeld-Connett, 2010).

Women are at a much greater risk of becoming sexually victimized and receiving other forms of physical assault than their male counterparts (North and Smith, 1993). Such contributing factors to this victimization came out of the vulnerability of their location and exposure to danger due to the lack of shelter. These women were more likely to sleep in areas with higher levels of crime, so simply being around left them exposed to dangerous individuals looking to do someone else harm. Due to their vulnerable status they are often the victims of rape. Additionally, substance abuse and mental illness have negative effects on an individual's ability to be vigilant and self-aware enough to avoid dangerous situations (Wenzel, Koegel and Gelberg, 2000).

Another issue that makes a homeless women's situation unique from a homeless man's are the issues involving reproductive health. Homeless women struggle with inadequate family planning. Although it takes two individuals to reproduce, the circumstances of the homeless woman often means the male is not a consistent or reliable member of her life, leaving the

responsibility of any children to her alone. Additionally, these women often have sexually transmitted diseases that go unmonitored and have unplanned pregnancies because they often fail to acquire or use birth control. It has been observed that women will see an increase in well-being after discovering they are pregnant, despite their obvious lack of resources in caring for the child. Becoming pregnant brings about a feeling of control in their lives, and occasionally this will translate to taking better care of themselves (Killion, 1998).

Humans desire and need connection with others. Despite the lifestyle that homeless women maintain they are not an exception. Often times they will find themselves aligned with homeless men who can complicate their situations, and these relationships can have unfortunate consequences. It is seen that relationships with homeless men increase the likelihood of substance abuse of alcohol and drugs (Carroll and Trull, 2002). Also due to their history of abuse and neglect, they are likely to stay in an unhealthy relationship which often includes sexual abuse. Woman can easily become the property of a man in the homeless culture. It is not uncommon for many of these women to resort to selling sex, usually at the demand of a man in their life (Ravenhill, 2008).

Homeless Men

Although the demographics of homelessness are changing with an increase in women and families on the streets over the past several decades, men are still seen in far greater numbers in the homeless population at approximately 67% in America (National Coalition for the Homeless, 2009a). In most cultures men and women often play separate but conjoining roles in maintaining society. There are expectations about behavior for both men and women, and an inability to live up to these standards can cause psychological distress. In the case of men, there is an expectation to bring in resources, also referred to as being a “breadwinner” (Kimmel, 2001). Status is an

integral part of identity in this way. It also revolves greatly around their ability to take care of others, especially a wife and children. An ability to take care of oneself and be independent is also essential. In all these areas of life homeless men have been unsuccessful. As a result uncertainty and distress about their masculinity often arise (Liu et al., 2009). Low self-esteem due to life failures can often establish itself as a contributing factor in substance abuse.

Lack of control and a decreased ability to fill the role of what a man “should be” can potentially result in dangerous behavior. Violence is seen with much more frequency in homeless populations. Sexual violence is also seen in much higher rates. In some cases, men who become homeless are initially at an increased likelihood to have maladaptive behaviors such as violence; and once homeless, they may feel an increased need to assert power in their lives where they usually have none (Ravenhill, 2008). Violence in homeless culture is explored further in proceeding sections.

Veterans, who are primarily men, are also at an increased risk of becoming homeless. Veterans represent a higher percentage of the homeless population at 32.7% than they do in the general population, which is 28%. Life in war is highly stressful. Techniques for survival in war zones such as hyper vigilance or violence becomes maladaptive in civilian life. Veterans are at a very high risk of Post-Traumatic Stress Disorder. The transition from duty to civilian life can be a very difficult time for many veterans, especially those who came from disadvantaged situations to begin with (Rosenheck, Frisman, Chung, 1994).

Culture

Homelessness is a deviance from the norm of society. As a result the norms and customs of the homeless culture are unique to them and develop to meet the needs of those within it. Once an individual becomes roofless, they must choose whether or not they will adapt. Due to

the nature of the homeless culture, those who more readily accept their condition are far more likely to remain homeless. Conversely, those who do not associate or consider themselves as part of the homeless culture spend less time on the streets. Those individuals who had especially traumatic childhoods are able to adapt more easily because they will not see this culture as more frightening than the situation they escaped from.

Emergence into Homelessness

When an individual is torn from the culture they once associated with, there can be intense anxiety associated and serious culture shock can occur. One of the greatest causes for anxiety and distress comes from the new way in which they are perceived by the mainstream society. The sense of self and security are lost upon entry into rooflessness. The homeless culture can serve as a refuge for those who have been rejected by the culture of their past. Homeless culture and community can be very close knit in order to meet the needs of its population. The move into homelessness can be gradual or sudden. Whether or not an individual adapts well to their new circumstances depends on the suddenness of their entry into homelessness. Those who gradually became roofless or knew that it was a possibility in the upcoming future found the entry less jarring, potentially because they had the opportunity to mentally prepare themselves more than those who are suddenly plunged into homelessness. The gradual transition is experienced by those who are precariously housed and those who already were interacting with homeless people, usually to drink. The sudden transition into homelessness is associated most with culture shock which can lead to insecurity and depression. The transition can often be facilitated by another homeless person who serves as a guide (Ravenhill, 2008).

Friendships

With homelessness comes isolation from mainstream society. In order to compensate for this feeling of loneliness and separation, strong bonds are created amongst members of this culture, which can reestablish their ontological security. Due to the circumstances of homelessness, there are few ways they can spend their time. As a result friendships arise out of constant contact with other homeless people. The friendships that arise between homeless people have a quality of understanding that the individual may not have received from mainstream society. They are able to relate to life circumstances and support each other. They gain trust through shared life experiences and the knowledge that the other has also suffered, and will not pass judgment. Since many homeless people suffer from substance abuse and mental health problems, they are most likely familiar with counseling practices and learn to incorporate techniques learned from these organizations to help each other. A deep sense of caring comes about in these relationships and homeless people work to help each other through tough times. With this support also comes dependence, and it has the potential to lock individuals in a cycle of rooflessness as a result; knowing that friendships like these were not available to them in the mainstream culture. Unfortunately, those individuals who are considered strong are especially relied on, and this could cause distress if they are unable to cope. This stress can lead to depression in the relied upon individual and push them towards substance abuse (Ravenhill, 2008).

Hierarchy

Just like in most human cultures, a hierarchy emerges among homeless individuals. The values and characteristics that create a leader in the homeless community are the opposite of what establishes power in mainstream culture, creating an inverted hierarchy. Those individuals

with the most trauma and time spent on the streets were the ones who received the most respect among their peers. Those who are homeless see life as being much more brutal than someone from the mainstream culture might. Therefore the ability to survive no matter what, is seen as the most desirable quality. The longer an individual has been living on the streets, addicted to alcohol or drugs and survived; the more they are admired. This drastically different set of values once accumulated in an individual makes reestablishment into mainstream society highly difficult. Those individuals who continually fail at resettlement are rewarded by their culture, assuring that they are set apart as being truly complex and disturbed. Pain and trauma can become badges of honor, with women bragging about the amount of times they had been raped, or other touting criminal records, especially if they were seen as respectable crimes within the community. Theft is an example of a respectable crime.

This attention and authority gained from exceptionally horrid pasts is also seen within the very social services aimed at helping these people. Those with particularly bad cases are set apart and given special attention, inadvertently reinforcing their behavior and gaining more respect from others. Occasionally this is seen to translate to the courts as well, with exceptions or lessening of punishment if horrific childhood events can be sited (Ravenhill, 2008).

Violence

This inversion of values seen in the homeless culture also relates to the amount of violence seen in comparison with the mainstream culture. Many homeless feel resentment and anger at the greater society because of their place outside. Due to an inability to adequately deal with their frustrations, and a feeling of impotence in the ability to change their situations, a misappropriation of aggressive action towards areas in their life they feel they may have more control over occurs. Therefore outbursts of violence against relatively mundane behavior are not

uncommon. What might be considered violent by an individual in the mainstream culture is often not perceived as such in the homeless culture. Violence instead is seen as an acceptable way to fix a problem between two individuals. Additionally there are high rates of behavioral problems for homeless individuals which may have been a cause of their homelessness or a result of it. Regardless, violence becomes an intrinsic part of the homeless experience. Due to the often violent pasts of homeless individuals, acceptance of this aspect of the culture is different from one person to the next. The individual has a choice to make when facing violence, they can either engage themselves in it, find themselves someone who can offer protection or attempt to separate themselves. The protector is usually very violent themselves, but withholds violence in exchange for respect gained from protecting others. Whether or not the individual engages in violence is often determined by past experiences. Those who experienced violence in childhood or had previously been engaged in a violent relationship are much more likely to view violence as normal. The prevalence of alcohol within the culture also plays a role in consistent violence. The more time an individual spent on the street the more likely they are to be immune to the violence and become passive observers to it. This tendency to use violence to solve problems serves as another road block in reemergence into mainstream society (Ravenhill, 2008).

Roadblocks to resettlement

Despite the violence, the inverted hierarchy and friendships formed on the streets play a major role in keeping people on the streets. The inverted hierarchy celebrates what mainstream society considers failure and the friends they have on the streets offer a kind of understanding and support many of these people have never had before. This has worked against many homeless people and much of the rehabilitation services have not incorporated these factors when working on getting homeless off the streets. The social connections and the release from

the demands of mainstream culture are a significant draw, especially for those who have already acclimated to the lifestyle. Only rehabilitation programs which incorporate the social and ontological needs of its clients will have the most success when it comes to making permanent change in the lives of these people.

When a homeless person does decide to make a change in his or her life, there are many obstacles they must face in their attempt to resettle. Unfortunately, these are often much more prevalent than genuine help. Therefore resettlement is a highly discouraging process. It takes a very strong willed, courageous person to persevere despite all the obstacles they face, and as a result many do not succeed in the current paradigm. The resources available to the homeless are limited and inadequate. Firstly, there is a lack of adequate information about where to receive help and advice in order to bring about change. Due to the social exclusion that homeless find themselves in, they do not know where to turn, especially if they do not have family. More recently, the internet has helped and has been seen as a useful tool in accessing information. Unfortunately access to the internet is often limited for a homeless individual, and once access to the internet is achieved the information can be unreliable or lacking.

Lack of Accommodation

Throughout the United States and Europe there is a substantial lack of space in hostels and housing accommodations where a homeless person can find shelter. There are waiting lists that may go on for months or even years, with little hope of getting shorter. In the 2011 U.S Conference of Mayors, it was found that 70% of the cities reported that shelters were forced to turn individuals away due to lack of space (The United States Conference of Mayors, 2011). Homeless individuals are often told of accommodations that are very far from their current location forcing them to make a choice between housing or social isolation. Accommodation is

difficult to access if the individual has substance abuse problems. Policies that some hostels have against drinking and smoking can be major deterrents from many with more severe addictions.

Lack of Consistent Social Connection

A major issue facing those individuals who manage to find housing accommodation was the lack of social connection as they transitioned from the streets to a house. The homeless culture is one that provides social support and constant contact if desired, but the skills and behaviors that are acceptable in the homeless culture are detriments in mainstream society. The transition from the streets to a house often involves frequent moves to different institutions which make maintaining social connections difficult. The transition can be hazardous, with a critical rate of relapses due to the major changes. It therefore becomes imperative that social structure and support are available that offer proper coping methods as opposed to the help received by homeless friends. These friends teach and use approaches which consistently involve using poor coping strategies such as numbing pain with alcohol and drugs or other maladaptive behaviors which could potentially cause them to lose ground in their conversion into mainstream life (Ravenhill, 2008).

Types of Shelters for the Homeless

Though this is not an exhaustive list, the major forms of shelters will be examined for their success or failure in helping the homeless. There are three major types of shelters for the homeless. Each has varying levels of involvement of staff with patients and different levels of success in helping to rehabilitate their clients who use these forms of housing. First Deinstitutionalization, the major catalyst for the creation of these types of shelters, will be explored.

Deinstitutionalization

In the 1950's and 60's there was a major shift towards deinstitutionalization. Deinstitutionalization was a movement which maintained that housing the mentally ill away in asylums and other institutions used for housing was not successfully making positive changes in the lives of those it treated, or society. These institutions were often overcrowded, unsanitary and associated with abuse of the patients (Goffman, 1961). There was a prevailing belief that these institutions encouraged dependence, inaction and isolation. Additionally with the emergence of many new drugs aimed at treating the mentally ill, the belief was that a move towards community mental health services would have more positive and significant benefits for these individuals. Unfortunately, deinstitutionalization is a movement filled with great intentions that have primarily fallen short. This is due to lack of funding. As a result many of the individuals who had previously been under the care of these institutions were released into the community, often with nowhere to go. There was often no accompanying community support to transition these individuals from a setting where they are treated for their mental illness and have many of their needs met, to suddenly taking care of themselves (Bachrach, 1976). Furthermore the majority of treatment for these individuals only comes in the form of medication (Harris, Hilton & Rice, 1993). Without a safety net in place, many of these individuals found themselves homeless and the need for these people to have shelter grew considerably.

Custodial Housing

Custodial Housing is an option for living that came about after deinstitutionalization. These establishments were often for-profit and did not have a high standard of living with many of the patients forced to share rooms. This housing option was also not aimed at rehabilitation but instead simply gave the residents care that consisted of meals and medication. Unsurprisingly

when research was done to see if patients were improving under this living situation, it was found that they were not. In a study conducted in 1976, foster family care, a form of custodial housing was compared to a group of patients that remained in a psychiatric hospital. They found no difference between the two groups. Each group became increasingly dependent on their custodial care and lost a great deal of independent social functioning. These individuals may be living together in a community but no methods of rehabilitation are implemented and therefore fall short of offering any substantive change (Murphy, Englesmann & Tchong-Laroche, 1976).

Supportive Housing

Supportive Housing came about in response to the failings seen in custodial housing. Mental health professionals wanted to have rehabilitation that took patients from full residency to independence through steps. These steps include halfway houses, quarter-way houses to almost complete independence. Within these institutions staff would provide rehabilitation programs focusing on establishing life skills. Unfortunately there were too few places to create the full continuum necessary to make this successful and often people were removed from communities that were supportive. Also towards the end of receiving treatment, independent housing offered no financial or rehabilitative support. Despite the lack of funding, studies done to test the effectiveness of supportive housing found that the patients showed improvements in reduced hospitalization and increased likelihood to work when compared to those patients still in psychiatric institutions (Fairweather, Sanders, Cressler, & Maynard, 1969).

Supported Housing

Supported Housing is an idea that housing should be the first priority in helping individuals and therefore should be given before any other kind of rehabilitation. In the United States this is supported by Section 8 which makes the resident pay for only 30% of their housing

costs with the government covering the rest. When people were asked what housing they most wanted, independent housing was the preference (Tanzman, 1993). They either wanted to live alone, with a friend or with a romantic partner but not with other individuals with mental health issues. They often said that the greatest barrier to achieving this was their lack of finances. These individuals also wanted staff support 24-hours a day but not live in staff.

There is evidence to suggest that having control and choice in regard to one's living situation brings about positive outcomes for those involved which often includes a reduction in psychiatric symptoms. In a study that compared supported housing with supportive housing it was inconclusive which showed more success, but there was a difference noted in the community that was built. Those who had a more hands on approach with staff and support showed less time on the streets (Nelson, Sylvestre, Aubry, George & Trainor, 2007). Supported Housing has become much of the standard practice within the United States, including programs seen in the McKinney-Vento Act, the HUD-VASH program and the Housing and Homeless Prevention and Rapid Re-Housing program.

American Models of Rehabilitation

The United States leads the industrialized world in homelessness with an estimated 3.5 million on the streets in 2008. In 2011 it was found that on an average night 636,017 individuals were sleeping on the streets, with 107,148 of those considered chronically homeless (National Alliance to End Homelessness, 2012). As the economy continues to stagnant, those individuals precariously on the fringes financially and socially may be forced out onto the streets. Although from 2009 to 2011 there was little to no increase in homeless population thanks to newly allocated funds provided through The Homelessness Prevention and Rapid Re-Housing Program, the funds used in programs which helped to keep the population from increasing have run out.

There is also a lag in data in regards to the population due to the transient nature of the population; and without available funds, a significant increase is expected to be seen (National Alliance to End Homelessness, 2012). Due to the current nature of the political atmosphere in America and its heavy reliance on money in pushing agendas, it is unsurprising that homelessness is not an issue that receives much attention on the national scene. Homeless individuals also cannot vote in many areas throughout the United States because of permanent address requirements in registering (Smith, 1987). Lack of money and inability to vote leave homeless people without a voice. Current policies need to be altered by implementing empirically demonstrated, successful methods of rehabilitation to combat this mounting problem in order to take care of these weakest members of society. First, current policies in place by the government will be examined for their practices and methods.

The McKinney-Vento Act

The McKinney Act, as it was originally known, was the first federal legislation in response to the homelessness issue in the United States. It was enacted into law on July 22, 1987 and later changed to the McKinney-Vento Act in 2000. In the law it states that the federal government recognizes that “the Nation faces an immediate and unprecedented crisis due to the lack of shelter for a growing number of individuals and families, including elderly persons, handicapped persons, and families with children, Native Americans, and veterans”. They also defined homelessness as “an individual or family who lacks a fixed, regular, and adequate nighttime residence” (U.S Department of Housing and Urban Development, 2012, p. 3). This act makes federal funds available for different services provided by the government. Its most significant programs are the supportive housing program, the shelter plus program and the single room occupancy program which in 2009 were consolidated into one program known as the

Continuum of Care Program. The Continuum of Care Program gives Section 8 housing through the single room occupancy program. Through supportive housing they receive transitional housing along with supportive services such as childcare and case management. McKinney-Vento also contains the Emergency Shelter Grant Program. Most of the programs focus primarily on emergency situations yet do little to address preventative measures. While they meet some of the critical needs of the homeless population, they are inadequate at best in creating long term solutions, especially for the chronically homeless. Some of these programs have demonstrated to be successful, such as the Supportive Housing Program programs but it remains underfunded. Support for this act has declined and since 1995 the funds budgeted towards these programs has dropped 28%. The amount of funds available is expected to shrink even farther. Since its inception some of its programs, notably the Job Training for the Homeless and the Adult Education Programs have been cut entirely from the McKinney-Vento Act (National Coalition for the Homeless, 2006).

HUD-VASH

In 1992, the US Department of Housing and Urban Development (HUD) and the US Department of Veterans Affairs (VA) established the HUD-VA Supported Housing (HUD-VASH) program in which VA intensive case management were linked to Section 8 housing vouchers, which provide rent subsidies to low-income individuals with disabilities. In a study conducted by Robert Rosenheck, homeless veterans were randomly assigned to one of three potential conditions. The first were placed in the HUD-VA group. This group would receive Section 8 vouchers for shelter and also receive intensive case management. In the second condition the participants only received case management without Section 8. The last condition was the standard veteran care. Standard veteran care consisted of short term case management in

addition to linking veterans up with additional VA programs and community services. In the research conducted, the benefits of HUD-VA were seen to be much more useful in decreasing time spent on the streets with a 16% increase in time spent off the streets for those in the HUD-VA over those who only received case management and a 25% increase as compared with the standard veteran's care. Additionally a decrease in the amount of time spent under the influence of alcohol or drugs was also seen for those in the program. Those in the HUD-VA were also much more likely than those assigned to the other group to show up to their check-ins with 77.8% showing up for follow up meetings. In the case management only group, 63.4% followed up and in standard care only 55%. This study demonstrated that it was not only case management that played a role in whether or not the homeless individual saw positive outcomes. It illustrated how shelter brings about a sense of autonomy and when combined with case management these individuals were more encouraged to get treated and hopefully work on the underlying roots of their homelessness (Rosenheck, 2003).

The Homelessness Prevention and Rapid Re-Housing Program

With the economic downturn beginning in 2007, there was much worry that those individuals on the fringes would be forced out onto the streets. In order to combat this, there were provisions set within The American Recovery and Reinvestment Act of 2009. The Recovery Act or ARRA was signed into law on February 17th, 2009 and allocated \$1.5 billion dollars to the Homelessness Prevention Fund. This act spends this money primarily on housing-first programs, which has shown some success in the HUD-VASH and McKinney Act programs. This money was provided through the HUD and facilitated through Section 8 with a focus on re-housing newly homeless, especially due to the high rate of foreclosures. This program was most successful in the veteran subpopulation of the homeless, with an 11% drop experienced.

Housing is essential and can save many individuals from the streets, especially if finances are the primary reason for homelessness. Providing cheap and affordable housing is obviously a major factor in helping to curb homelessness, yet it is still inadequate in dealing with the root issues (National Alliance to End Homelessness, 2012).

European Perspective: Denmark

Denmark is the southernmost Scandinavian country with a population of 5,543,453 citizens in 2012 (Central Intelligence Agency, 2012). It consistently ranks among the happiest places in the world to live due to its wealth and high standard of living (Earth Institute: Columbia University, 2012). As a socialist welfare state, Denmark delivers many services to its citizens including health care and free education at all levels. For 2009 to 2012 the Danish government has allocated an additional 500 million DKK (~85,000,000 USD) to new initiatives which would reduce homelessness in their country. The official definition for homelessness in Denmark is as follows: “Homeless people are defined as persons who do not own or rent homes or rooms, but are obliged to avail of temporary accommodation, or live temporarily, without a rental contract, with relatives, friends or acquaintances. Homeless persons also include those who do not have a place to stay for the coming night” (European Federation of National Organizations Working with the Homeless, 2009, p. 4). Like the United States, the Danish policy is that of “housing first”. It has been shown that immediate access to shelter upon entering homelessness can help curtail further damage that can occur from prolonged time spent on the streets. Access to housing does not stand alone but is used in conjunction with other programs to meet the personal needs of the citizen, due to the unique and complicated circumstances that lead an individual into homelessness. The government’s new homeless strategy has four major goals. The first is that no one is sleeping on the streets. The second is that young homeless citizens be

given options besides care homes or shelters because of the continued social marginalization that occurs with life at a care home. The third goal is that individuals not spend more than 3 to 4 months staying at a care center before they enter a home of their own, with the proper government support. The fourth goal is that those individuals waiting to be released from prison or a mental health institution have accommodation before they are released. The Danish government has recognized three methods that have shown the most success in rehabilitation and has decided to implement them thusly. These programs are Assertive Community Treatment, Critical Time Intervention and Individual Case Management (European Federation of National Organizations Working with the Homeless, 2009).

Denmark, in part due to its small size, but also due their humanitarian priorities, has excellent data on the homeless, including fairly accurate information about the number of homeless individuals on a given night. They discovered this number to fluctuate from around 5,000 people a night and around 11,000 to 13,000 affected each year (Benjaminse, 2007). This means that even when the highest estimates are used, the homeless population in Denmark is at 0.2% a year.

Comparisons: American vs. Danish Policy

When the governmental policies of the United States are compared to those of Denmark, there is a great disparity in quality and scope of care when it comes to the homeless population. Homelessness has become a major priority of the Danish government while remaining a fringe issue, at least on the political scene, here in America. Per capita they have a much smaller homeless population yet are spending more than the United States when compared to Gross Domestic Product. Overall Denmark has a much greater emphasis on shared sacrifice in all aspects of life. While Denmark has some of the highest tax rates in the world, the services they

receive in return mean that not only those who can afford these services have access to them. It also stems from a belief in their culture that you are not the only person responsible for your position in life, but instead have a more realistic understanding of what it means to be a member of a society. This reality being that each of us exists in an interconnected web and therefore your place within it is directly depends on others. The rehabilitation programs that they have implemented to combat their homelessness problem is also indicative of their philosophy to share social burdens.

Rehabilitation from Homelessness

Much of the public policy and programs currently used to help homeless individuals have proven to be severely lacking in their ability to make positive change in the lives of those they are supposed to be helping. This is seen in the United States and Europe with advocates of homelessness often playing just as big a role in an individual's continued rooflessness. Bureaucracy and the ensuing inadequate access to proper resources is one of the biggest issues a homeless person faces in their attempt to resettle. Homeless individuals often learn to cope with their situation and become acclimated to their way of life, and as a result only after a serious trigger occurs will they realize the need to change their lives. One trigger is reaching "rock bottom". Many see their bottom as a chance to change, because they believe they can either improve themselves or die on the streets. Although there is some evidence reaching rock bottoms works to bring about change, there is also evidence that many homeless individuals do not have such a bottom. Death of a friend can also serve as this catalyst. Other forms of trauma, such as assault or rape may also serve as the trigger to resettle (Ravenhill, 2008).

Lastly, the trigger that is often most ignored, was the realization that the homeless individual was cared for. This is the hardest to incorporate into rehabilitation services because it

is dependent on an individual's kindness and not simply money allocated by the government into subsidized housing or detox centers. Community building should be reevaluated and harnessed as a tool that has the potential to make major positive changes in the life of a homeless person and their transition from the streets to a home (Ravenhill, 2008).

The Importance of Social Connection

Common wisdom would indicate that having strong social relationships help to maintain overall life happiness and health. Over recent decades there has been much empirical evidence to support this idea. Friendships have shown to increase happiness even when personality traits that increase happiness, such as optimism, are accounted for (Demir & Weitekamp 2007). This seems to be because friendships are a symbiotic relationship where basic needs can be fulfilled through the other person. Friendship can fill the need for companionship, intimacy, support and autonomy. As social animals that naturally form units, companionship is a need that has naturally evolved in our characters. Our species was able to succeed in units, with better chances at acquiring resources if teamwork was utilized. Espousing the importance of close bonds may be cliché, but its importance should not be underestimated, especially when it comes to life changing rehabilitation to bring an individual off the streets. As previously mentioned, one of the major catalysts that inspires individuals to make a change to their life and seek help is the realization that someone cares for them. The importance of friendship can be further explained through Self-Determination Theory.

Self-Determination Theory

The Self-Determination Theory (SDT) tries to explain why people are motivated to engage in the behaviors that they do, and what these activities do to create well being or lack thereof. It focuses on intrinsic motivation and those activities that are inherently rewarding. SDT

asserts that the three major psychological needs of humans include the need for competence, autonomy and relatedness. Competence refers to the ability to effectively handle the environment in which one lives. Relatedness refers to the need for companionship and autonomy refers to the need for an individual to control their circumstances. These needs are thought to be innate and are applicable to all genders and cultures. These needs are seen to be particularly lacking in homeless populations. Through the lens of SDT, it becomes simple to explain why friendships form, their usefulness, and their ability to improve quality of life. Friendship is seen as one of the biggest contributors to happiness together with personality traits like optimism. When personality traits are a detriment to happiness, such as excessive neuroticism, friendship can help to improve happiness. SDT also explains how consistent discouragement can create patterns of behavior that limit motivation. The majority of homeless individuals have suffered from these forms of discouragement, such as childhood abuse. Patterns of behavior needed for survival in an abusive household often more closely resemble the maladaptive behaviors that make one “successful” for life on the streets than for life in the general population (Deci, Ryan, 2002).

Proposed Rehabilitation Programs

There are many conjoining issues that come together before a person becomes homeless: substance abuse, mental illness, lack of social support and financial distress. In the United States the McKinney Act, HUD-VASH and the more recent Homelessness Prevention and Rapid Re-Housing Program primarily focus on treating individuals only once they have reached critical emergency situations and does not work to prevent future hospitalization or future crisis situations. Instead we will focus on the Danish paradigm and the programs previously discussed that the Danish government has been implementing. Although the programs being used in Denmark were developed in the United States, they have not been implemented on a wide scale

and their potential benefits have not had the chance to truly present themselves through social and financial support by the American government and its people.

This thesis states that if federal money in the United States could be allocated to programs on the state level responsible for creating Assertive Community Treatment (ACT) and Critical Time Intervention (CTI) programs in conjunction with Section 8 housing, decreases and permanent solutions to the homeless issue could begin to be seen. What makes ACT and CTI programs different is their incorporation of such previously ignored aspects of rehabilitation, primarily the social needs of its patients. Social Determination Theory provides evidence for the benefits and necessity of social relationships. Social connection has been proven again and again to be an essential part of a thriving person and these programs are able to create a mix of social structure with the introduction of positive life skills in order to make long term permanent change in its clients.

Critical Time Intervention

Created in New York City during the 1990's, the Critical Time Intervention model offers a method to assist those individuals to make the transition out of homelessness successfully. "Critical Time Intervention (CTI) is an empirically supported, time-limited case management model designed to prevent homelessness in people with mental illness following discharge from hospitals, shelters, prisons and other institutions" (Critical Time Intervention, 2011). CTI is a safety net that focuses on developing independence, appropriate life skills and coping techniques in association with a network of social support as an individual makes the transition from institutions to independent living in their own home. What makes this approach different from Assertive Community Treatment, which will be discussed in more detail subsequently, is that it is time limited, lasting 9 months. The first phase of this treatment involves intensive care

between the case worker and the client. This involves the case worker making home visits, meeting with family, joining the client in attendance of community services, offering support and advice, mediating conflicts and any additional issues that they are qualified to help with. This intensive care lasts from one to three months. Not only does this assure that the client is attending to their personal improvement during a time that they would usually be on their own, but it also allows relationships formed in the institution to be maintained and enhanced throughout the transition. The second phase begins during the fourth month of treatment. This is the time that allows the client to test the skills they have acquired. Though they still meet with their case worker on a fairly regular basis, they are encouraged to deal with their issues on their own, though support is always available if needed. This stage allows the case worker and the client to see if the systems that have been put in place are working properly. If subsequent renegotiations need to be made, than this is the time to do it. The third phase takes place during the eighth month of CTI. This stage includes the full transition of CTI services to the individual and support network members. It also focuses on setting up long term management programs. This program is ideal for those who need support, but are not in such psychological distress that they cannot eventually take their life into their own hands. Keeping timetables creates motivation to keep moving in their path towards rehabilitation. Critical Time Intervention is a great tool and could easily be applied to a majority of homeless people who need support during the critical time of transition. However for individuals who have suffered from more chronic mental health issues and homelessness, programs like Assertive Community Treatment may offer more relief.

Assertive Community Treatment

Assertive Community Treatment (ACT) was established in the 1970's in Wisconsin during the time when major deinstitutionalization was occurring; with its focus on helping

rehabilitate mentally ill individuals who struggled with maintaining friendships, jobs or housing. Though not originally intended for use with homeless populations the co-morbidity rates of mental illness and homeless have made the transition easy and logical. What makes ACT unique from other rehabilitation programs is its focus on consistency and continual support when needed. ACT is implemented through a team of 10 to 12 professionals with varying skills, including psychiatrists, substance abuse counselors, nurses and other therapists. This team is limited to treating approximately 100 clients, therefore ensuring that the team members can devote enough personal time to each client in order to best meet their needs. This team of several professionals means that if a client needs support every day, it is guaranteed that one of the members will be available. Additionally if a client does not like one member they have other members whose resources they can utilize. This is an improvement from a single caseworker mode. Contrastingly in the single caseworker model, if issues arise between the client and caseworker it may become a detriment to the rehabilitation of the client. If one member of the ACT team moves or quits, there is already a support system of other team members for the client to rely on, ensuring much more consistency in treatment than other models of care. ACT is also unique because it utilizes home visits with the client in order to make the skills they learn more quickly adaptable to the real life situations where they will be lived out, as opposed to an artificial rehabilitation setting. Most importantly for many clients, is the offer that support and treatment can be utilized for as long as the client needs. In the ACT model there is no time limit or release of a client who is too difficult. This is what makes ACT more suitable for clients, like the severely mentally ill, whose needs have been most underserved in other programs (Stein & Santos, 1998).

ACT is successful at addressing a client's need to have a consistent social structure. Not only does the team dynamic work for the client in these ways, but the ability of the team to help the client is increased by their ability to use each other as resources. All the members of the team are qualified professionals and within this structure the client is able to learn positive coping skills, so when the time comes that they choose the end their treatment with their ACT team they have all the adequate skills. This group dynamic has also shown to keep the members of the ACT team from experiencing such high rates of burn-out that standard one on one care is associated with.

Cost-Benefit Analysis of Proposed Rehabilitation Programs

It has been demonstrated that Critical Time Intervention and Assertive Community Treatment have the potential to make substantial and permanent changes in the life of homeless people, especially those who are suffering from substance abuse problems or mental illness (Bond et. al, 2001; Draine & Hermain, 2007). Despite this it would be unreasonable to implement these practices on a large scale if the resources and costs needed were out of proportion with the improvement that could be gained by implementing them. Critical Time Intervention and Assertive Community Treatment will be explored in more economic terms in order to see how they compare with the current costs used in the rehabilitation of the homeless.

Critical Time Intervention Cost-Benefit Analysis

Critical Time Intervention has demonstrated to be highly successful when compared to usual treatments for homelessness. In in 2003 a study was conducted in New York City which compared Critical Time Intervention with the standards practices, for their success in rehabilitation from homelessness rates and cost. They found that the mean cost of CTI including housing and all resources was \$52, 374 with usual care costing \$51,649. However, the CTI group

averaged 32 nights homeless during treatment, with the usual care group spending almost triple that at approximately 90 days homeless. This translates to only an addition of \$152 for each night spent off the streets. This demonstrates that CTI was relatively no more expensive than the standard practices used for rehabilitation for the homeless. Additionally, CTI begins to cost approximately \$1,613 less than the usual care when looking at the 9 months after receiving treatment. This was attributed to decrease in hospitalization or other crisis services. Those who underwent CTI were much more able to secure housing for themselves and were more likely to be holding down a job. When the 9 months of treatment and the 9 months after treatment were added those who had received CTI had an average of 508 nights spent off the streets, compared to 450 in the usual care group. Despite this initial cost increase, those placed in the CTI group experienced much more satisfaction and were able to incorporate the skills they acquired through CTI for a longer time than those going through standard care (Jones et. al, 2003).

Assertive Community Treatment Cost-Benefit Analysis

ACT is highly involved method of rehabilitation, and on first glance it would appear that the constant attention that each patient needs would be very costly and unsustainable if implemented more widely throughout the nation. On average ACT costs approximately between \$10,000 to \$15,000 per client. However this price is consistent with other forms of rehabilitation (National Alliance on Mental Illness, 2012). In a meta-analysis conducted in 1999 by Eric Latimer on the major studies studying the cost-benefit analysis of ACT, it was found that ACT is in fact less or equally expensive compared to the current systems in place, especially when the costs are examined over a long period of time. The primary reason for this is that ACT brings about a major reduction in hospitalization as much as 78% (Latimer, 1999). In studies that compare the results of patients going through ACT compared to the standard emergency care, it

becomes even clearer that the benefits of ACT should not be trivialized. ACT has proven itself to be a successful solution that lasts. The skills and tools gained through this program continue to benefit the clients even if they are no longer under the supervision of ACT. In an updated study conducted by Latimer in 2005, the continued success and cost reductions seen in the use of ACT are shown. Latimer concludes that ACT when properly implemented will essentially pay for itself in the costs offset by decreased hospitalization or incarceration (Latimer, 2005).

When viewed in the long term, generally several years, ACT begins to rise ahead of other methods even further. The ability to instill the characteristics that create a thriving individual in the long term is what sets ACT apart from other forms of rehabilitation. It can take years to work through many of the issues that these individuals face. ACT has to undo year's and even decade's worth of maladaptive coping skills and negative and defeating thought processes that have become so thoroughly ingrained in these individuals after so much time on the streets. What makes this type of care better than standard emergency care is that it often leads to the permanent solution. Additionally, patients receiving ACT are much more satisfied with the treatment that they received and are more engaged in their recovery than those patients receiving other forms of treatment (Latimer, 1999; Latimer, 2005).

What should also be included in this cost benefit analysis, but has yet been studied in depth is the influences that these individuals can make once they are reestablished as contributing members of society. If these people are given the tools to get off the streets and live independently then they are able to go back into the work and consumer forces. In a world economy that necessitates having an income in order to buy goods, having members of society such as the homeless, who do not contribute therefore become a hindrance.

Cost of sustaining these programs should not be the primary reason to implement ACT however; especially since it has been demonstrated that they do not require more resources than the current models, yet shown dramatic enhancements in client satisfaction. The focus should instead be on the clinical benefits that are consistently observed, which translates to drastic improvements in life quality.

Danish Homeless Shelter Perspective

While studying abroad in Denmark in the spring of 2011, I was lucky enough to have the opportunity to volunteer at a homeless shelter. From this experience I was inspired not only to write this thesis but to devote my career to this especially needy population. I had the opportunity to talk with other volunteers and the homeless themselves about their experiences while I was there. I was able to see interesting trends that appeared to be very different from homeless individual's experiences in the United States. Several individuals were immigrants who had fled from their home countries as refugees. These individuals did not have the social welfare system at their disposal and therefore relied on shelters more than Danish nationals did. What was most interesting about the homeless population in Denmark is the severity of the issues these individuals face. Due to the social welfare system, when a citizen becomes unemployed or loses their home, the state automatically protects them. They are eligible for unemployment benefits for years after losing their jobs, and housing is given for free to those who cannot afford it. There were even several volunteers at the shelter who were unemployed themselves, yet at no risk of losing their homes thanks to this system. Therefore these individuals, who are homeless despite all the financial help from the government, are usually substance dependent or very mentally ill. Denmark's emphasis on programs like ACT, which have shown great success with rehabilitating the mentally ill and substance dependent, is logical and apparent.

American Agency Perspective

In order to supplement research conducted in this thesis, the opinions of professionals in the field and the agencies they work for were inquired upon. Upon approval from the Institutional Review Board at Salve Regina University, agencies were approached with an informed consent form (Appendix A) and questionnaire (Appendix B) asking about the environmental and psychological factors involved in homelessness and its rehabilitation. Subsequently this summary represents some of the answers and opinions of those who work closely with the homeless population.

Agency professionals agreed that some of the most influential motivators to encouraging a homeless individual to pursue help is a belief that there is someone who cares for them. They most often felt that a feeling of trust between an agency worker and a homeless person could encourage the homeless individual to care more about themselves. This could also come from the outreach of their family. They also agreed that personal motivators occasionally played a role, specifically if the individual thought that if they continued in their current fashion that they would have serious health problems or even die. However, many thought that some of these homeless individuals do not have rock bottoms, and the threat of death was not a deterrent. Additionally, it was noted that the people they most often saw exiting homelessness were those who had not been homeless for very long and therefore had not thoroughly acclimated to that way of life.

The behavior that agency workers tried to encourage in their clients most was self-respect with an emphasis on maintaining their safety. Case workers must work at the level of impairment of the person they are dealing with, meaning that they are not able to work up on the hierarchy of needs. Instead the most basic needs and health are made a priority. Most of these homeless see

themselves as worthless and are depressed and angry. They did not care that they were killing themselves with drugs because they did not see how anything could be done to improve themselves or their situation, or why they deserved to treat themselves in a healthy manner. They are “too messed up” for such considerations. Therefore another message that the agency workers tried to instill was “not to give up”. Many of these homeless individuals have already tried everything to get off the streets. As a result they are incredibly hopeless. Though agency workers tried to encourage hope, nevertheless they reflected that the homeless rarely made plans for the future and this fed back in their loop of unhealthy behavior.

Agency workers thought that relationships among the homeless could potentially be utilized as a tool for rehabilitation, but there was also a largely held belief based on some of their past experiences, that they were a significant hindrance as well. These agency workers witnessed many fights over begging areas, drugs or alcohol, along with encouraging inappropriate behavior in each other. They stated that the most common way humans learn is through watching, and the behaviors they imitate can be a limitation in their rehabilitation. But if positive behaviors are encouraged it can in turn do a lot of good. They believed that perhaps if these friendships were led and overseen through a “leader” at a rehabilitation center to encourage proper behaviors that these friendships could be more useful in making positive change. In relation to this, many of the workers were familiar with programs such as Assertive Community Treatment and Critical Time Intervention and saw them as underutilized and underfunded programs with great outcomes, though no one interviewed had ever worked in these types of programs. The biggest cause for their success was the use of teamwork and shared burden for the rehabilitation agency workers, and by extension the increased likelihood that they could give each one of their clients the time and attention they deserved.

In regards to whether or not substance abuse and mental illness were precursors or consequences of homelessness, there was a split or uncertainty from the agency workers. It is often hard to tell when dealing with a community at large and it changed from person to person. There was agreement that if substance abuse or mental illness was not already present in an individual upon entrance into homelessness, that the chances of it appearing greatly increases. This especially is true for substance abuse due to its high prevalence in the homeless culture as a social activity.

Many agency workers agreed that social isolation was the most damaging aspect of homelessness in relation to human thriving. They reflected that this population is completely invisible to the society at large. Many also agreed that even more damaging was the severe decreases in health that homeless individuals experience. Body and mind have a reciprocal relationship and therefore both are significant. The decreases in health quality are often the thing that can be physically seen by these workers, while psychological distress is something that can often only be inferred or learned after a relationship is established.

Many of the agency workers agreed that if healthy relationships were created around these homeless individuals that they would likely see improvements in quality of life and desire to make positive changes in themselves. They cited from their experiences that a self of worth gained through relationships with agency workers and others helped to recreate a desire to make more of their lives, though others admitted that it is not necessarily true in all cases. They stated that these relationships once established occasionally led to passivity and more acceptance of their circumstance because they were having many of their psychological needs met through these relationships. Primarily it was noted that as humans we cannot heal alone and there needs to be support and friendship from other people that care. This vital role is fulfilled by agency

workers and others within the homeless community. Programs aimed at creating community were seen in most agencies interviewed. Such programs range from clinical activities like group therapy to more amusing activities like watching a film and discussing.

The federal and local policies were seen as inadequate by everyone interviewed. They also stated there due to a lack of public outcry, there is little chance of it becoming a priority issue. Instead they believed society feels like these individuals deserve their place in life, and it is punishment for an inherently bad character. They saw money received as the biggest contributing help from the government, with a few citing the Homelessness Prevention and Rapid Re-Housing program as a program that did much to help them, but it is now scheduled to run out in June. They felt that the scope of government help was vastly insignificant and underfunded when compared with the need. With most interviewed being from Rhode Island, many of them lamented Rhode Island's record numbers in homelessness since the economy downturned in 2007. A few approximated that they receive about a third of what they need to fund their programs from the state, with staff and resources being cut. Others stated that if it were not for community donations, they did not know how their agencies would continue running. A few brought up that they thought legislators, for political reasons, were unwilling to make long term investments that brought about real long term solutions while preferring short term quick fixes that appear to make changes and lack substance.

Conclusion

Homelessness has existed for centuries and is a dynamic and every growing problem. Though it exists throughout the world, its contrast to the standard of life of the majority in the western world makes it especially socially ostracizing for those in this condition. The quality of life and life expectancy are considerably lower than in the general population, and the suffering

these individuals are forced to endure on a daily basis should cause moral outcry. Unfortunately, this has consistently shown to not be the case, at least not on a national or federal level. This thesis does not claim to present how to get these programs into working policy or how to make this issue become a priority for our government, but it does provide evidence which advocates that it should be. We have seen that homelessness has multiple layered triggers that accumulate over an average of 7 to 9 years. These triggers include abusive parents or guardians, frequent moves, substance abuse and mental illness. The unique culture of the homeless community has also been analyzed with a focus on the benefits and problems it creates for those within it; from the strong and encouraging social bonds they form, to the high levels of violence and inverted hierarchy.

The community created in homeless culture can be a hindrance to those within it, reinforcing unhealthy models of behavior and coping strategies. Despite the cultures harmful effects on those within it, it is still seen as preferable for many because it has the key ingredient to human happiness, social connection. Critical Time Intervention and particularly Assertive Community Treatment add this ingredient and much more to their rehabilitation. These programs understand the subtle issues involved with treating these particularly vulnerable individuals and focus on what makes a person improve their circumstances, particularly a community of social support. When combined with the fact that these programs are no more expensive than the current models of dealing with homelessness, it becomes exceedingly clear that the United States should follow in Denmark's footsteps and implement these programs directly into the federal budget.

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Appendix A

Agency Informed Consent

I consent to this interview. I understand that it is voluntary and I am free to leave the interview at any time. The responses of this interview will be kept anonymous and confidential. The individual agencies and the individual providing information will not be disclosed at any time. This interview is only meant to be exploratory in order to supplement a Senior Pell Honors Thesis. The information gathered will only be part of a summary in conjunction with 10 other participating agencies. Upon completion all participating agencies will receive this summary and all data will be destroyed.

Name: _____

Agency: _____

Date: _____

Appendix B

Homeless Agency Questionnaire

These questions are to serve as exploratory research in the creation of a senior thesis at a local college. The identities of the individuals and agencies will be kept anonymous and the interview responses will only be released as a summary in combination with several different agencies throughout Rhode Island. Participating agencies will receive the summary and long abstract of the paper upon completion.

Environmental Factors

- Under what circumstances have you seen your clients exit homelessness?
- What environmental factors do you believe motivate a homeless person most to change their circumstances?
 - Are they mostly negative? (hitting rock bottom) or positive? (realizing there are people who care about them)

Psychological Factors

- What behaviors do you encourage most in your client?
- Do you believe that relationships among homeless individuals could be utilized as a tool for rehabilitation?
- Do you attempt to foster community development among your clients?
- Are you familiar with rehabilitation programs such as Assertive Community Treatment or Critical Time Intervention?
 - If yes, have you or would you ever participate in this kind of program?
 - If yes, why?
- What would you say is the most psychologically damaging aspect of being homeless? (ex.social isolation or exposure to the elements, substance abuse)
- In the case of substance abuse, do you more often see it as a precursor to homelessness or a consequence of homelessness?
- Additionally, in the case of mental illness, do you more often see it as a precursor to homelessness or a consequence of homelessness?
- Do you believe establishing a group of trusted individuals around a client could help in their rehabilitation?
 - If yes, why? And what evidence based on your experience lead you to think so?
- Are there federal and local policies that help your work? And conversely are there federal and local policies that serve as roadblocks?
 - If yes, what would you change about governmental policies currently in place?
- Is there anything about your current programs that you would change?
 - If yes, why?